United States Medical Licensing Examination® (USMLE®)

Certification of Prior Test Accommodations (CPTA)

To be completed and signed by medical school official responsible for student disability services.

Applicant Name: _____ **USMLE ID#:** __ -__ __ __-__ __ __-__

I certify that _____ has officially approved and continuously
Name of School
provided the following accommodations for the above applicant beginning on _____
Date (Month/Year)

1. Accommodation(s) provided for **computer-based, written, or other assessments**:

   Reason for accommodation(s): _____

If student is requesting accommodations for **Step 3**:

2. Accommodation(s) provided for **clinical education settings (e.g., ambulatory, inpatient, laboratory-based clinical work)**:

   Reason for accommodation(s): _____

Name of School Official:_____ Title:_____
Print Name of Official Title of Official

Signature of Official:_____ Date:_____

Telephone Number: (_____)_____

E-mail or fax completed form to:
Disability Services
NBME
Telephone: (215) 590-9700
Fax: (215) 590-9422
E-mail: disabilityservices@nbme.org

Please Note: This form is not a Request for Test Accommodations. Go to https://www.usmle.org/step-exams/test-accommodations for detailed information and instructions on submitting a request for accommodations.

DEFENDANT'S EXHIBIT
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